STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì '		INSTRUCTION 00	(X3) DATE S COMPLI		
MDILAN	or connection	DENTI TOTATION NOWIDER.	A. BUII			12/04/2014	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF P	PROVIDER OR SUPPLIER				SHELBY ST		
BETHAN	Y VILLAGE ASSIST	TED LIVING			APOLIS, IN 46227		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000000							
	This visit was for	r State Residential	R00	0000			
	Licensure Survey		1100				
	Electionic Surve	, .					
	Survey dates: D	ecember 2, 3, and 4,					
	2014	••••••••••••••••••••••••••••••••••••••					
	Facility number:	001121					
	Provider number						
	Aim number: N						
	Survey team:						
	Patti Allen, SW-	TC					
	Marcy Smith, RN						
	Dottie Plummer,						
	ĺ						
	Census bed type:						
	Residential: 71						
	Total: 71						
	Census payor typ	oe:					
	Medicaid: 45						
	Total: 45						
	Residential samp	ble: 7					
	These state findi						
	accordance with	410 IAC 16.2-5.					
	_ · · · ·	ompleted on December					
	10, 2014; by Kin	nberly Perigo, RN.					
LABORATOR	L Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S S	IGNATURI	<u> </u>	TITLE	I	(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Page 1 of 20 State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
			B. WIN			12/04/	/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					SHELBY ST		
BETHAN	Y VILLAGE ASSIS	TED LIVING		INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000216	shall be delineated manual, but at a nassessment shall the following: (1) The resident 's mental status. (2) The resident 's activities of daily li (3) The resident 's admission and set (4) If applicable, the self-administer met (d) The evaluation writing and kept in Based on intervithe facility failed ability to self-adsemi-annually as policy for 2 of 6 self administration (Resident #4 and Findings included 1. The clinical resident #4 had not limited to, diadmitted to the facility of the Residential Care	content of the evaluation of in the facility policy pinimum the needs include an evaluation of a physical, cognitive, and a independence in the ving. It is weight taken on miannually thereafter. The resident 's ability to edications. It is shall be documented in the facility. It is evaluate residents' minister medications indicated by facility residents reviewed for on of medications. It Resident #44) Execord review, completed the p.m., indicated diagnoses including, but abetes. The resident facility on 7/1/13.	ROC	00216	1. Resident # 4 and # 44 both have a physician order for sel administration of medications. Resident # 4 and # 44 both ha an updated Self Medication Assessment form. 2. All reside have the potential to be affect by the same deficient practice therefore all resident Service Plans are being audited by Assistant Clinical Director and General Manager for compliant Any Service Plan indicating the resident may self administer medications is then further checked to ensure that a physician order is present to administer and that the Self Medicaiton Assessment form completed and attached behing the Service Plan.3. New mean now include an audit of new admission charts to occur with	f	12/30/2014

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 2 of 20

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			B. WING			12/04/	2014
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			SHELBY ST		
BETHAN	Y VILLAGE ASSIS	TED LIVING			APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	·	In	DATE
	^	l daily assistance with			the first 48 hours of admission the Assistant Clinical Director.	•	
	medications and also self administered				Audit will ensure that if Service		
	medications. Th	ne form included			Plan states self administration		
	instructions to at	ttach a self-medication			medications is allowed that a s	self	
	assessment if the	e resident was able to self			medication physician order is		
	administer medi	cations.			present, and that the Self		
					Medicaiton Assessment form i completed and attached behin		
	The recapitulation	on of physician's orders			the service plan. 4. Service pla		
	_	12/31/14, included an			of all residents will be reviewed		
	order for Humalog (a short acting insulin)				quarterly care plan meetings.		
		ministered with meals as			These reviews will include an		
	well as a sliding scale dosage based on				audit of the serivce plan regard		
	_	lts. The start date for the			self medication by the resident Audit will specifically identify the		
	_	he was 2/25/14. The			physician order and the Self	iat	
	_				Medication Assessment form a	are	
		order for blood sugar			present and up to date on cha	rt.	
	_	day with an origination					
		The resident also had an					
		(a long acting insulin) 38					
	I -	dtime. The Humalog					
	_	se was: 201 - 250=2					
	units, 251 - 300=	=4 units, 301 - 350=6					
	units, 351 - 400=	=8 units, and to call the					
	physician for a b	blood sugar >400.					
	During an interv	riew with Resident #4 on					
	_	a.m., the resident					
		ff drew the insulin into					
	the syringe and t						
		e insulin. The resident					
		ff would occasionally					
		lin injections if the					
	•	feeling well, but the					
	_	y administered the					
	injections.		1				

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 3 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN	G		12/04/	2014
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	ROVIDER OR SUPPLIER			3530 S	SHELBY ST		
BETHAN	Y VILLAGE ASSIS	TED LIVING		INDIAN	APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	riew with the Clinical					
Director on 12/2/14 at 3:45 p.m., the							
	Clinical Director	r indicated the resident					
	self administered	d insulin dosages after					
	the staff drew th	e insulin into the syringe					
		The Clinical Director					
	indicated the res	ident had been					
		nsulin injections since					
	admission to the	_					
	admission to the	racinty.					
	The clinical record lacked a self						
		ssessment for the					
		ked a physician's order to					
	self administer n	nedications.					
	During an interv	riew with the Clinical					
	_	/14 at 10:30 a.m., the					
		-					
		r indicated a self					
		ssessment was not					
	•	esident #4 prior to					
	12/2/14.						
	0 m 1: : :	1					
		ecord review, completed					
		30 p.m., indicated					
	Resident #44 had	d diagnoses including,					
	but not limited to	o, diabetes. The resident					
	was admitted to	the facility on 2/18/14.					
		for Residential Care dated					
	2/18/14 and 8/22	2/14, indicated the					
	resident required	l daily assistance with					
	medications.						

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 4 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI	DING	NSTRUCTION 00	(X3) DATE COMPL 12/04 /	ETED
			B. WING		DDDDGG GYRY GRAND GYD GODD	12/04/	2014
NAME OF I	PROVIDER OR SUPPLIER	S.			DDRESS, CITY, STATE, ZIP CODE SHELBY ST		
RETHAN	Y VILLAGE ASSIST	TED LIVING			APOLIS, IN 46227		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	REGUERTORTOR	ESC IDENTIFICATION OR MATTERN		1710	<u></u>		DATE
	A Salf Administ	ration of Medications					
Review dated 2/18/14, indicated the resident was fully capable of applying							
	topical ointments						
	transdermal patc	hes.					
		on of physician's orders					
		2/31/14, indicated the					
resident had an order for Voltaren Gel (a							
topical gel used to treat pain in joints) to							
be applied daily in the evening, Skin Prep							
	(a type of medical	ated wipe used to form a					
	protective barrie	r to the skin) to be					
	applied to heels	once a day, Nizoral					
	shampoo (a shan	npoo used to treat flaking					
	and scaling of th	e scalp) used 3 times a					
	week, and TED	(Thrombo Embolic					
	Deterrent, a type	of stocking used to					
		ots in the legs) hose to be					
	l ~	orning and removed at					
		oitulation of orders					
		for self-administration of					
	medications.	tor son dammistration or					
	incurcations.						
	A review of the	Medication					
		Record (MAR) for					
		14, lacked documentation					
		n of the Voltaren Gel, the					
		-					
		ne TED hose for all 30					
	days of the mont	n.					
	TI. MAD C 31						
		ovember 2014, lacked					
	documentation o	of the application of the					

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 5 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMPI 12/04		
	PROVIDER OR SUPPLIER		3530 S	DDRESS, CITY, STATE, ZIP COD SHELBY ST APOLIS, IN 46227	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	month.	of the 30 days of the				
	Director on 12/2 Clinical Director self-administered and would check	iew with the Clinical /14 at 3:45 p.m., the r indicated the resident d all of the treatments t to see about the elf-administration of				
	Director on 12/3 Clinical Director self-administrati completed 2/18/	iew with the Clinical /14 at 10:30 a.m., the r indicated the on assessment was 14, and was not updated e Plan was updated				
	Director provide Resident policy indicated the pol used by the facil "The evaluatio to admission and semi-annually" used to determin shall included.	2:00 a.m., the Clinical of the Evaluation of dated 4/2014, and licy was the one currently ity. The policy indicated, in shall be initiated prior dishall be updated. The resident evaluation is see the level of careand If applicable, the to self-administer.				

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 6 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
					12/04/2014	
			B. WING	ADDRESS CITY STATE ZIR CODE		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
				SHELBY ST		
BETHAN	Y VILLAGE ASSIST	ED LIVING	INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID	BROWING BLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
R000217	410 IAC 16.2-5-2(e)(1-5)				
	Evaluation - Defici					
		pletion of an evaluation,				
		appropriately trained staff				
		entify and document the				
	services to be prov	vided by the facility, as				
	follows:					
		ffered to the individual				
	resident shall be a	ppropriate to the:				
	(A) scope;					
	(B) frequency;					
(C) need; and(D) preference;of the resident.(2) The services offered shall be reviewed and revised as appropriate and discussed by						
		ffanad aball ba navianos d				
		acility as needs or desires				
		facility or the resident				
	may request a ser					
		on service plan shall be				
		by the resident, and a				
	-	e plan shall be given to the				
	resident upon requ	· ·				
	· · ·	n and documentation of				
		is needed if evaluations				
	subsequent to the	initial evaluation indicate				
	no need for a char	nge in services.				
	(5) If administratio	n of medications or the				
		ntial nursing services, or				
		licensed nurse shall be				
		cation and documentation				
	of the services to b	•				
		ew and record review,	R000217	1. Resident # 4 now receiving	12/30/2014	
	the facility failed	l to ensure blood glucose		blood glucose monitoring and	od.	
	monitoring was a	performed and sliding		sliding scale insulin administer as ordered by the physician.2.		
		administered as ordered		diabetic residents have the	/ WI	
		for 1 of 2 residents		potential to be affected by the		
				same deficient practice, theref	ore	
		alin administration.		all resident Service Plans are		
	(Resident #4)			being audited by Assistant		
				Clinical Director and General		

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 7 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			A. BUII B. WIN		<u> </u>	12/04/	2014
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t			SHELBY ST		
BETHAN	Y VILLAGE ASSIS	TED LIVING			APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ΤF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings included The clinical reconstruction of the clinical reconstruction of the clinical reconstruction of the recapitulation of	ord review, completed on p.m., indicated Resident is including, but not ites. on of physician's orders including, but not ites. on of physician's orders included an including insulin, indicated with meals as scale dosage based on its. The start date for the included included including insuling insuling insuling including insuling in			Manager for compliance. Any Service Plan indicating that a resident is diabetic will be furth reviewed to ensure that the required blood glucose monito and sliding scale insulin administration is being comple as ordered by a physician and documented properly by nursing personnel on the resident's Medication Administration Record. 3. New measures put into place now include an audinew admission charts to occur within the first 48 hours of admission by the Assistant Clinical Director. Audit will ensure that if resident has diagnosis of diabetes and requires blood glucose monitoring and sliding scale insulin administered, that proper physician order is in place and documentation is consistenetly present regarding blood glucose and sliding scale information. All nursing personal have been in-serviced by Assistant Clinical Director, regarding insulin/sliding scale blood glucose monitoring. 4. Corrective actions will be monitored by audits conducted.	ner ring tted ng t on ure of t a ace g e unel and	
	November 2014	, indicated the resident			the quarterly care plan meeting Audits will specifically identify		
		ose of 209 on 11/1/14 at			physician orders regarding blo		
		nould have received 2			glucose and sliding scale insul		
	•	cale insulin. No sliding			are present. Medication		
	_	s documented as given.			Administration Records will be		
	Scare msumi was	s documented as given.			audited daily for sliding scale		
		1, , , 11, 00			insulin dependent residents by		
	_	se result at 11:00 a.m. on			the Assistant Clinincal Director		
	11/1/14, was 202	2 and the resident should			Daily audits will be conducted	tor	

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 8 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			B. WIN			12/04/	2014
NAME OF I	DROVIDED OD GUDDU IEE		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	X.		3530 S	SHELBY ST		
	Y VILLAGE ASSIS			l	APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	the next 30 days, then Assista	nt	DATE
have received 2 units of sliding scale insulin. No sliding scale insulin was					Clinical Director will continue		
		-			audits weekly for 30 days, and		
	documented as g	given.			finally monthly, which will be		
	m 11 1 1	1, , , , , , , , ,			on-going. This along with the open plan team review should ensure		
		se result at 6:00 a.m. on			the deficient practice will not	C	
	· ·	7 and the resident should	recur.				
		units of sliding scale					
		ing scale insulin was					
	documented as given.						
	The blood gluco	se result at 11:00 a.m. on					
	~	6 and the resident should					
	·	units of sliding scale					
		C					
		ing scale insulin was					
	documented as g	given.					
	The documentat	ion lacked results of a					
		4:00 p.m. on 11/3/14,					
	and lacked docu	_					
		f any sliding scale					
	insulin.	runy snamg seare					
	mouilli.						
	The documentate	ion lacked results of a					
		6:00 a.m. on 11/4/14,					
	and lacked docu						
		f any sliding scale					
	insulin.	<i>J</i> ~					
	The blood gluco	se result at 6:00 a.m. on					
		and the resident should					
	· ·	units of sliding scale					
		ing scale insulin was					
	documented as g	-					
		, · - ·					

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 9 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/04/2014
	PROVIDER OR SUPPLIER		3530 S	ADDRESS, CITY, STATE, ZIP CODE SHELBY ST APOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	11/6/14, was 200 have received 2 insulin. No slidi documented as g				
	11/7/14, was 320 have received 6	se result at 6:00 a.m. on and the resident should units of sliding scale ng scale insulin was given.			
	11/7/14, was 204 have received 2	se result at 11:00 a.m. on 4 and the resident should units of sliding scale ng scale insulin was given.			
	11/7/14, was 347 have received 6	se result at 4:00 p.m. on 7 and the resident should units of sliding scale ng scale insulin was given.			
	11/9/14, was 238 have received 2	se result at 6:00 a.m. on 8 and the resident should units of sliding scale ng scale insulin was given.			
	11/10/14, was 20 should have rece	se result at 6:00 a.m. on 05 and the resident cived 2 units of sliding to sliding scale insulin			

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 10 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
			B. WIN			12/04/2014	
			J. 1111		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				SHELBY ST		
BETHAN	Y VILLAGE ASSIST	TED LIVING			APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(2	X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	IE	LETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DA	TE
	was documented	as given.					
	The blood glucos	se result at 6:00 a.m. on					
	_	06 and the resident					
		eived 2 units of sliding					
		o sliding scale insulin					
		-					
	was documented	as given.					
	The decrees of	1 1					
		ion lacked results of a					
		11:00 a.m. on 11/12/14,					
	and lacked docur	mentation of the					
	administration of	f any sliding scale					
	insulin.						
	The documentati	ion lacked results of a					
	blood glucose at	11:00 a.m. and 4:00					
	p.m. on 11/16/14						
	•	of the administration of					
	any sliding scale						
	uny sname scare	mgwilli.					
	The blood glucos	se result at 6:00 a.m. on					
		94 and the resident					
		eived 4 units of sliding					
		o sliding scale insulin					
	was documented	as given.					
		1 4.00					
		se result at 4:00 p.m. on					
	•	72 and the resident					
	should have rece	eived 4 units of sliding					
	scale insulin. No	o sliding scale insulin					
	was documented	as given.					
	The blood glucos	se result at 11:00 a.m. on					
	_	74 and the resident					

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 11 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/04/2014				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3530 S SHELBY ST INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE COMPLETION			
	scale insulin. Tl	eived 4 units of sliding the documentation ident received 2 units of ulin.						
	11/24/14, was 30 should have recesscale insulin. The	se result at 4:00 p.m. on 61 and the resident eived 8 units of sliding he documentation ident received 6 units of ulin.						
	11/28/14, was 23 should have rece	se result at 11:00 a.m. on 36 and the resident eived 2 units of sliding o sliding scale insulin d as given.						
	11/28/14, was 24 should have rece	se result at 4:00 p.m. on 45 and the resident eived 2 units of sliding o sliding scale insulin I as given.						
	11/29/14, was 3 should have rece	se result at 6:00 a.m. on 16 and the resident eived 6 units of sliding o sliding scale insulin I as given.						
	11/29/14, was 30 should have rece	se result at 11:00 a.m. on 00 and the resident eived 4 units of sliding o sliding scale insulin						

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 12 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI.		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED	
				B. WING 12/04/2014				
					DDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹			SHELBY ST			
BETHAN	Y VILLAGE ASSIS	TED LIVING	INDIANAPOLIS, IN 46227					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT			COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	was documented	l as given.						
	The blood gluco	se result at 4:00 p.m. on						
	11/29/14, was 29	90 and the resident						
		eived 4 units of sliding						
		o sliding scale insulin						
	was documented							
	was documented	i as giveii.						
	The blood aluga	se result at 6:00 a.m. on						
		40 and the resident						
	· · · · · · · · · · · · · · · · · · ·							
		eived 2 units of sliding						
		o sliding scale insulin						
	was documented	l as given.						
	Th. 1.1 1 . 1							
		se result at 11:00 a.m. on						
	· ·	90 and the resident						
		eived 4 units of sliding						
	scale insulin. No	o sliding scale insulin						
	was documented	l as given.						
	_	riew with the Clinical						
		1/14 at 3:45 p.m., the						
	Clinical Director	r indicated the staff						
	performed the bl	lood glucose testing and						
	was expected to	document the blood						
	glucose results and the amount of insulin administered each time blood glucose testing was completed and the sliding scale insulin was administered.							
	scale msum Was	s aummistereu.						
	On 12/4/14 at 10):10 a.m., the Clinical						
		ed the Glucose Meter						
	•							
	1	esting policy dated						
07/2011, and indicated the policy was the								

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 13 of 20

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING			COMPLETED 12/04/2014			
			B. WING		DDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER		3530 S SHELBY ST					
BETHAN	Y VILLAGE ASSIST	ED LIVING	INDIANAPOLIS, IN 46227					
(X4) ID PREFIX		CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE	
	number 41 of the "Document res Clinical Director	bd by the facility. Step e policy indicated, ults of glucose" The indicated the did not olicy regarding sliding ninistration.						
R000306	(g) Medications and shall be disposed appropriate federal and disposition of destroyed medication the resident 's conclude the following (1) The name of the (2) The name and (3) The prescription (4) The reason for (5) The amount dis (6) The method of (7) The date of the (8) The signature of the disposal of the (9) The signature of the disposal of the drup Based on record the facility failed resident's medical according to facilify for 1 of 2 dischalation of 473)	ervices - Noncompliance iministered by the facility in compliance with I, state, and local laws, any released, returned, or ion shall be documented clinical record and shalling information: he resident. Strength of the drug. In number. disposal. Sposed of. disposition. If disposal. If the person conducting drug. If a witness, if any, to the generative and interview, to ensure a discharged cutions were disposed of clity policy and state law, reged residents reviewed for medications. (Resident)	R000	0306	1. Resident # 73 no longer resides in the facility.2. All nurs personnel in-serviced by Assistant Clinical Director regarding proper discharge of resident's medications upon discharge of reisdent from facility.3. Assistant Clinical Director will review the status of medications for all residents		12/09/2014	
	Findings include	: :			discharged from the facility to ensure facility policy is followed	d.4.		

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 14 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	00	(X3) DATE COMPL 12/04 /	ETED			
	NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 S SHELBY ST INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)			TE	(X5) COMPLETION DATE		
TAG	The clinical recoreviewed on 12/3 Diagnoses for the were not limited depression, high and history of block Resident #73 was 9/21/14, and discon 10/10/14. Recapitulated ph September, 2014 was receiving the and as needed medischarge from the service of the servi	rd of Resident #73 was 3/14 at 9:45 a.m. e resident included, but to, multiple sclerosis, blood pressure, anxiety, ood clots. s sent to the hospital on charged from the facility rysicians's orders for ry, indicated Resident #73 e following scheduled edications prior to her he facility: meg (micrograms) mg (milligrams) de 20 meq mg		TAG	Once nursing personnel have discharge paperwork complete Assistant Clinical Director and General Manager will review paperwork for proper documentation and disposition medicaitons.	e or	DATE		
	buspirone 15 mg	;							

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 15 of 20

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED		
			B. WING		12/04/2014	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
DETIIAN	V VIII I ACE ACCIO	TED LIVING		SHELBY ST		
BETHANY VILLAGE ASSISTED LIVING			INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
TAG		· · · · · · · · · · · · · · · · · · ·	TAG	DEFICIENCE (DATE	
	trazodone 100 m klonopin 0.25 m	_				
	substance)	g (a controlled				
	· · · · · · · · · · · · · · · · · · ·	etaminophen 5-325 mg (a				
	controlled substa					
	meclizine 25 mg	· ·				
	acetaminophen 3					
	loratadine 10 mg	_				
	ketorolac 10 mg	5				
		(a controlled substance)				
	tramador 50 mg	(a controlled substance)				
	No documentation	on was found in Resident				
		ch indicated what the				
	facility did with					
	_	r she was discharged.				
	medications are	i she was discharged.				
	On 12/3/14 at 10	0:30 a.m. the				
		dicated the facility had a				
		which nursing was				
	_	ument the disposition of				
		medications at the time				
	of discharge.					
	On 12/3/14 at 3:0	00 p.m., the Clinical				
		d a Medication Return				
		9/14, which indicated the				
		ntadine and donepezil				
	had been returned to the pharmacy because the resident had been discharged. At that time, the Clinical Director					
	· ·	s not able to find any				
	other documenta	•				
		e rest of Resident #73's				
	medications.					

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 16 of 20

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
AND TEAN	of connection about the intermediate.	A. BUILDING	00	12/04/2014	
		B. WING	ADDRESS, CITY, STATE, ZIP CODE	1270 1120 11	
NAME OF I	PROVIDER OR SUPPLIER		SHELBY ST		
BETHAN	IY VILLAGE ASSISTED LIVING		IAPOLIS, IN 46227		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	DROWIDER'S BLANCE CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	On 12/4/14 at 10:10 a.m., the Clinical Director provided a policy, dated 7/2011, titled, "Disposition of Medications When				
	a Resident Is Discharged From the				
	Facility," and indicated it was the policy currently used by the facility. The policy				
	indicated, "Upon discharge from the				
	facility, the patient's drugs are to: a) Be				
	released with the patient or b) Be				
	returned to the pharmacy for				
	credit/destruction, or c) Be destroyed by				
	two licensed nursing personnelThe				
	nurse will document in the clinical				
	recordAll narcotics must be accounted				
	for"				
R000414	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.				
	Based on observation and record review,	R000414	1. All nursing staff have been	12/30/2014	
	the facility failed to ensure hand washing		in-serviced by Assistant Clinic	al	

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 17 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		COMPLETED		
			A. BUILDING B. WING	-		12/04/2014		
			_	ET ADDRESS. CITY	, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIEF	R		S SHELBY ST				
BETHAN	Y VILLAGE ASSIS	TED LIVING	INDIANAPOLIS, IN 46227					
(X4) ID		TATEMENT OF DEFICIENCIES	ID		DER'S PLAN OF CORRECTION	(X5) COMPLETION		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
TAG		LSC IDENTIFYING INFORMATION)	TAG	Dia (*	DATE		
		ecording to facility		Director on proper hand washing.2. All residents have the				
	1	edication administration			be affected by the	u ie		
	for 3 of 5 resider			-	cient practice, theref	ore		
	medication admi	inistration. (Residents #4,			be performed on all			
	#24, #21, Licens	ed Practical Nurse #1)		_	aff by Assistant Clini			
	Findings include	: :		over the ne that proper	nd General Manage ext 30 days to ensul r hand washing s are being followed	re		
	During an obser	vation on 12/3/14 at		1 .	res being put into			
	1	ensed Practical Nurse #1,			all nursing personne			
	· · · · · · · · · · · · · · · · · · ·	orm a finger stick blood			monthly in-service			
		d to measure blood			hand washing by Clinical Director.			
		ent #4. She washed her			Clinical Director or			
	• /	oves, cleaned the glucose			vill conduct rounds	to		
	'1	•		ensure pro	per hand washing			
	_	w gloves, performed the			ing medication			
	_	l test, removed her			tion.4. General			
	_	her hands, put on		1 -	vill review montly training sign in log t			
	-	the insulin in a syringe,			t all nursing staff is			
		inge to Resident #4 to			y receiving training.			
		, then, removed her						
	gloves, sanitized	her hands, donned						
	gloves again, cle	aned the glucose meter,						
	performed the fi	ngerstick blood test on						
		After the test was						
		emoved her gloves,						
		• ,						
	sanitized her hands, regloved, set the insulin pen to the correct dosage, and gave the insulin to Resident #24 to administer. When that was completed, she removed her gloves, sanitized her							
	hands, and admi							
	medication to Re	esident #21.						
	LPN #1 was not	observed to wash her						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	NSTRUCTION 00		E SURVEY PLETED			
ANDILAN	OI CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING			COMPLETED 12/04/2014		
			B. WING	DDDECC CITY CTATE 7ID CO.				
NAME OF F	PROVIDER OR SUPPLIEF	₹		DDRESS, CITY, STATE, ZIP COI SHELBY ST	DE			
BETHAN	Y VILLAGE ASSIS	TED LIVING	INDIANAPOLIS, IN 46227					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		SUMMARY STATEMENT OF DEFICIENCIES ID		PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX	•	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP				
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE		
	1	e after the initial						
	preparation.							
	On 12/3/14 at 1:	45 p.m., the Clinical						
		ed a policy, dated 4/2014,						
	•	ashing," and indicated it						
	•	urrently used by the						
		licy indicated, "An						
		nent of infection control						
	is hand washing	. All staff members must						
	wash their hands	s after each direct						
	resident contact	for which hand washing						
	is indicated by a	ccepted professional						
	practice."							
	0 10/2/14 12	20 4 61 1						
		20 p.m., the Clinical						
	•	ed a training protocol,						
		'Medication Validation,"						
	· ·	This is what we use when						
		urses." The protocol hes hands prior to passing						
	medications."	nes nanus prior to passing						
	incuications.							
	On 12/4/14 at 10:10 a.m., the Clinical							
	Director provide	ed a policy, dated 3/2013/						
	titled, "Glucose Meter Cleaning & Testing," and indicated it was the policy							
		y the facility. The policy						
	indicated, "Wasl	h handsPut on gloves						
	[clean blood glu	cose meter]Wash or						
	sanitize hands	Put on clean gloves						
	[perform test]I	Remove glovesWash or						
		Put on gloves[clean						
	blood glucose m	neter]remove						

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 19 of 20

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/30/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI	ING	00	COMPL	ETED	
			B. WING			12/04/	/2014
NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 3530 S SHELBY ST INDIANAPOLIS, IN 46227				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			DEFICIENCY)		DATE
	glovesWash ha	ands"					

State Form Event ID: ERFP11 Facility ID: 001121 If continuation sheet Page 20 of 20